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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

YMCA AND YWCA SUPPLEMENTAL

Named Insured: _____
Location Address: _____
E-mail: _____
FEIN Number: _____
Person to contact for safety questions/mailings/info: _____
Web Address: _____
Risk Management Contact: _____ Cell Phone: _____ Email: _____

REQUIREMENTS FOR SUBMISSION

- Completed and signed/dated PHLY YMCA and YWCA Application
- Completed ACORD Applications
- Currently valued insurance company loss runs for current policy period plus three (3) prior years
- Statement of Values (for blanket and agreed amount property coverage)
- Athletic Participants sample Waiver Forms
- Brochures / Promotional Materials

SECTION I - GENERAL APPLICATION INFORMATION

1. Service offered (check all that apply):
   ☐ Youth Recreation ☐ Overnight Camp ☐ Fitness Center ☐ Counseling Services
   ☐ Fitness Classes ☐ Child Day Care ☐ Adult Day Care ☐ Babysitting
   ☐ Day Camp ☐ Snack Bar/Restaurant ☐ Pools ☐ Other Social Services
   ☐ Temporary Lodging for Transients ☐ Shelters (Women, Children, Homeless)
   ☐ Other (describe): _____
2. Type of organization: ☐ For-Profit ☐ Non-Profit ☐ Co-ed ☐ Boys ☐ Girls
3. What are the Applicant's hours of operation? From: _____ To: _____
   Number of members: _____ Number of active members: _____ Staff to child ratio: _____
4. How long has the Applicant's director been in his or her position with their facility? _____
   How many total years experience does the director have as a facility director? _____
   Does the director or any other employee train outside groups in anything, such as CPR or lifesaving? ☐ Yes ☐ No
   If yes, describe:
   _____
5. Does the Applicant loan or lease their director or employees to any other operations, either owned or not owned. ☐ Yes ☐ No
   If yes, explain who, how often, and for what purpose:
   _____
6. Does the Applicant dispense medication? ☐ Yes ☐ No
   If yes, are written instructions from parents required prior to administering medications to minors? ☐ Yes ☐ No
   a. Is all medication stored in its original containers? ☐ Yes ☐ No
   b. Is all medication inaccessible to children? ☐ Yes ☐ No
   c. How many of the following medical professionals are on staff?
      RN: _____ LPN: _____ EMT: _____ MD: _____ PA: _____ Other:(describe): _____
   d. Do the professionals carry their own malpractice insurance? ☐ Yes ☐ No
      If yes, does Applicant request a certificate of insurance as proof? ☐ Yes ☐ No
   e. Are any of the medical professionals volunteers? ☐ Yes ☐ No
   f. Is a log kept to record each time a medication is administered? ☐ Yes ☐ No
7. Does the Applicant accept special needs participants? ☐ Yes ☐ No
   If yes, please complete Section XVII
8. Does the Applicant take participants on field trips or travel? ☐ Yes ☐ No
   If yes, please complete section XVI

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9. Does the Applicant rent or lease their facility to outside entities? ☐Yes ☐No
If yes, complete Section XVIII
10. Does the Applicant sponsor or participate in special events or fundraisers? ☐Yes ☐No
If yes, please list all types of events. Use additional paper if needed.

11. What is the Applicant's income from all sources (last 12 months)?

Membership Fees:	$_____	Snack Bar:	$_____
Fund Raisers:	$_____	User Fees:	$_____
Donations:	$_____	Child Care:	$_____
Other:	$_____	Other:	$_____
Bingo (indicate # of admissions annually)		TOTAL ALL RECEIPTS:	$_____

12. Does the Applicant accept adjudicated youth or adults as volunteers? ☐Yes ☐No

SECTION II – MANAGEMENT PRACTICES

1. Does the Applicant have sign in / out procedures for:
Staff? ☐Yes ☐No
Clients / Residents? ☐Yes ☐No
Visitors / Public? ☐Yes ☐No
2. Are all minors required to sign in? ☐Yes ☐No
3. Are all entrances attended? ☐Yes ☐No
4. Type of security provided for the protection of the Applicant's clients / residents?
☐Guards ☐Video Cameras ☐Other: _____
5. What measures are taken to monitor client activities?
6. What precautions does the Applicant take to prevent non-staff members from accessing unauthorized areas of the property?
7. Does the Applicant have incident reporting procedures and committee reviews? ☐Yes ☐No
8. Is the Applicant's staff made aware of reporting procedures? ☐Yes ☐No
9. Does the Applicant have a plan for medical emergencies? ☐Yes ☐No
10. Is there always someone trained in CPR and first aid on the premises? ☐Yes ☐No
11. Does the Applicant have Automatic External Defibrillators? ☐Yes ☐No
Are staff members trained to use it? ☐Yes ☐No
12. Does the Applicant have a written and enforced no smoking policy? ☐Yes ☐No
13. Are "no smoking" signs posted in all areas not designated for smoking? ☐Yes ☐No
14. Are smoke detectors installed in all sleeping areas? ☐N/A ☐Yes ☐No

SECTION III – PROFESSIONAL LIABILITY

Hiring Practices

1. Does the Applicant require their staff (paid and volunteer) to complete an employment application? ☐Yes ☐No
If no, please explain:
2. Does the Applicant conduct a personal interview for each prospective staff member? ☐Yes ☐No
3. Does the Applicant verify employment related references? ☐Yes ☐No
4. Does the Applicant share written job descriptions with all staff members? ☐Yes ☐No
5. Name of executive director / manager: _____
6. Number of years experience in this field: _____ Number of years at this facility: _____
7. Specialized training or education: _____
8. Are any staff members under eighteen (18) years of age? ☐Yes ☐No
If yes, list their position(s) and how they are supervised: _____
9. What is the staff turnover rate for the last twelve (12) months? _____
10. Does the Applicant provide workers compensation for:
☐All staff members ☐Workshop Employees ☐Contractors ☐Consultants
11. Is the staff required to report to the administrator all incidences that may result in a claim? ☐Yes ☐No
If yes, is a written report kept? ☐Yes ☐No Are they reviewed? ☐Yes ☐No
12. Are clients referred to specialists when appropriate? ☐Yes ☐No

13. Are files maintained to protect confidentiality of clients? ☐Yes ☐No
14. Does the Applicant do any consulting work? ☐Yes ☐No
    If yes, please explain:

15. Does the Applicant's current insurance program provide professional liability coverage? ☐Yes ☐No
    If yes: ☐Occurrence ☐Claims Made – Retroactive date: _____
    Limits: $_____ Effective dates: _____
    Carrier: _____
16. **Consultant / Independent Contractors**
    Are there written agreements with independent contractors? ☐Yes ☐No
    Are certificates of malpractice / professional liability insurance obtained and maintained for all contracted service providers (independent contractors)? ☐Yes ☐No
    Please indicate the limits of liability: $_____
17. Annual Staffing – Employees, Independent Contractors and Volunteers
    Total number of: Full time employees: _____ Part Time Employees: _____ Volunteers: _____

Staffing	# of Employees		# of Contracted		Total Annual Volunteer Hours Worked
	FT	PT	FT	PT	
Psychologist					
Medical Director (Admin Only)					
Nurse Practitioner					
Physician Assistant					
Pharmacist					
Paramedic EMT					
Psychiatrist					
Physician-Hospice					
Pediatrician					
Physician-No Surgery					
Dentist					
Optometrists/Ophthalmologist					
Licensed Social Worker					
Sociologist					
Registered Nurse (RN)					
Licensed Practical Nurse (LPN)					
Physical Therapist					
Optician					
Orthotics & Prosthetics (O&P) Certified Practitioner					
Counselor (Guidance, Vocational)					
Social Worker					
Occupational Therapist					
Speech Therapist					
Clergy / Rabbi / Pastor					
O&P Certified Technician					
Teacher					
Nutritionist / Dietician					
Residential Manager					
Home Health Aide					
Day Care Worker					
O&P Certified Fitter					
O&P Certified Assistant					
Adoptions					
Foster Care					
*Other (describe): _____					
*Other (describe): _____					

F/T = Full Time – over 20 hours per week/ P/T = Part Time – up to 20 hours per week.
*Please describe "other" staff positions not listed in the above chart in the provided area.

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18. **If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.**
19. **If the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians carry their own medical malpractice insurance, we may provide vicarious medical professional coverage for the entity as respects to the professional services rendered on the insured's behalf. Coverage for the entity will require the following: The Professional's name, medical license number, medical specialty and proof that the professional carries adequate limits of insurance (at least $1million limit of liability). Proof of insurance may be satisfied by submitting a copy of the professional's declaration page and/or certificate of insurance.**

SECTION IV – HIRING / SCREENING

1. Are employees screened for drug, alcohol and sexual abuse? ☐ Yes ☐ No
2. Check all methods used in hiring all employees or independent contractors:
   ☐ Drug Testing ☐ Criminal Background Checks – Federal ☐ Criminal Background Checks – State
   ☐ Personal Interview ☐ Reference Checks ☐ Sexual Abuse Registry ☐ Validate Driver's License
   ☐ Validate Education ☐ Validate Work History ☐ Verify Current Certification / Professional License
   ☐ Validate Personal Auto Insurance and Limits (if operating owned vehicle during company hours)
3. How are references checked: ☐ Written ☐ Verbal ☐ Both
   If verbal only, please explain:

   _____
4. Are all of the above methods done prior to hiring? ☐ Yes ☐ No
   If no, please explain:

   _____

SECTION V – SEXUAL ABUSE ☐ N/A

1. Does the Applicant's current insurance program include Abuse and Molestation Coverage? ☐ Yes ☐ No
   If yes, ☐ Occurrence or ☐ Claims Made – Retro Date:_____ Limit of Liability: $_____
   Carrier:_____ Effective Date:_____
2. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? ☐ Yes ☐ No
3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if the Applicant has incident of abuse? ☐ Yes ☐ No
4. Are there written complaint procedures and are they displayed prominently? ☐ Yes ☐ No
   If yes, explain:_____
5. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ Yes ☐ No
6. Are formal written procedures in place for hiring? ☐ Yes ☐ No
7. Do volunteers work directly with clients? ☐ Yes ☐ No
8. Is there formal staff training on child/sexual abuse, including how to recognize the signs? ☐ Yes ☐ No
9. What procedures are in place to make sure no relationship occurs between staff and clients?
10. Are there procedures prohibiting closed door one-on-one meetings / counseling? ☐ Yes ☐ No
11. Is there more than one person responsible for the welfare of any single patient? ☐ Yes ☐ No
12. Have any incidents resulted in an allegation of sexual abuse? ☐ Yes ☐ No
    Was the case settled? ☐ Yes ☐ No Was the case taken to trial? ☐ Yes ☐ No
    Amount paid for damages to the victim: $_____
13. Does the Applicant run criminal background checks on employees? ☐ Yes ☐ No
14. Does the Applicant run criminal background checks on volunteers? ☐ Yes ☐ No

SECTION VI – SWIMMING POOLS ☐ N/A

1. Is there a trained lifeguard on duty? ☐ Yes ☐ No
   If yes, how many?_____ During what hours?_____
2. The pool area includes:
   ☐ Jacuzzi ☐ Whirlpool ☐ Hot Tub ☐ Spa ☐ Kiddie Pool ☐ Water Slide ☐ Trampoline
3. Is the pool completely fenced with a self-locking gate? ☐ Yes ☐ No
   If yes, what is the height?_____
4. Pool location: ☐ Indoor ☐ Outdoor
5. Is there a diving board? ☐ Yes ☐ No If yes, what is the height?_____
6. Are depths clearly marked? ☐ Yes ☐ No

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7. Is life saving equipment readily accessible? ☐ Yes ☐ No
8. Is walking surface around the pool non-skid and in good condition? ☐ Yes ☐ No
9. Is the staff trained in water safety? ☐ Yes ☐ No
10. Are all areas of the pool, including the bottom, visible at all times? ☐ Yes ☐ No
11. Are "swim at your own risk" signs posted with pool rules? ☐ Yes ☐ No
    Do the posted rules meet state and local regulations? ☐ Yes ☐ No
12. Is the storage of pool chemicals secured? ☐ Yes ☐ No
13. How often is the pool cleaned?_____
14. Does the Applicant have specific guidelines regarding closing the pool due to water contamination? ☐ Yes ☐ No
15. Are all swimming pools and spas complaint with the Virginia Graeme Baker Pool and Spa safety act? ☐ Yes ☐ No
    If no, provide time table and action plan:

SECTION VII – PREMISES / LIFE SAFETY

1. If the building you occupy was built prior to 1971; has it been inspected for lead paint? ☐ Yes ☐ No
   If no, what is the plan for abatement?_____
2. Does the property have aluminum wiring? ☐ Yes ☐ No
   If yes, has it been retrofitted with one of the PHLY approved connectors by a licensed
   Electrician?(indicate which one):COPALUM? ☐ Yes ☐ No AlumiConn? ☐ Yes ☐ No
   Date updated:_____
   Please supply retrofit documentation or statement from installing contractor.
3. Has asbestos material been:
   ☐ determined **not** to be present ☐ removed or ☐ protected to prevent flaking?
4. Does the Applicant have any plans for renovations or new construction? ☐ Yes ☐ No
5. Does the Applicant's facility exit directly to the outside? ☐ Yes ☐ No
   To ground level? ☐ Yes ☐ No
6. Are there any non-ambulatory clients? ☐ Yes ☐ No
   If yes, how many?_____ Any located above the first floor? ☐ Yes ☐ No
7. Please indicate which of the following fire suppression devised are currently in use:
   ☐ Automatic Sprinkler System ☐ Central Station Fire Alarm System ☐ Smoke Detectors
   ☐ Manual Pull Fire Alarms ☐ Fire Extinguishers ☐ Other:_____
8. Are all areas of buildings with wet pipe sprinkler systems (hidden or unhidden) maintained at a minimum temperature of 40° F, and / or provided with proper insulation or heat tracing to prevent pipe freeze-ups? ☐ Yes ☐ No
9. How many exits are there?_____
   Are all exits clearly marked & illuminated? ☐ Yes ☐ No
10. Are all exit doors equipped with panic hardware? ☐ Yes ☐ No
11. Is there a fire escape? ☐ Yes ☐ No
    If yes, please describe:_____
12. Does the Applicant have a written emergency evacuation plan? ☐ Yes ☐ No
    If yes, are the emergency evacuations procedures and floor plan posted? ☐ Yes ☐ No
    Has Applicant established a central meeting point outside the building? ☐ Yes ☐ No
    Does the emergency plan include notification to the fire department? ☐ Yes ☐ No
    How often are drills held?_____
13. Does the Applicant have emergency lighting or backup generators in the event of a power failure? ☐ Yes ☐ No
14. Does the Applicant have a formal maintenance housekeeping program in place? ☐ Yes ☐ No
15. Does the Applicant own or rent any parking facilities? ☐ Yes ☐ No
    If yes, are they well lit? ☐ Yes ☐ No
16. Is the hot water heater set to a temperature of 120 degrees? ☐ Yes ☐ No
    Does the Applicant have an equipment maintenance program in place? ☐ Yes ☐ No
17. Has the Applicant's facility been inspected by an insurance company or independent inspection firm? ☐ Yes ☐ No
    If yes, by whom?_____
    On a separate sheet, please list any deficiencies and corrective actions in the past three (3) years:
18. Does the Applicant comply with board of health regulations and with building codes? ☐ Yes ☐ No
19. Are medical facilities, such as a first aid or nurse's station located on the premise? ☐ Yes ☐ No
20. Please indicate the dates of the latest updates regarding the following common hazards:
    Electrical/Wiring:_____ Plumbing:_____ Heating:_____
    Type of Heating: _____
    Type of Roof:_____ Age of Roof:_____

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SECTION VIII – KITCHEN EXPOSURE ☐N/A

1. Is cooking permitted on the premises? ☐Yes ☐No
2. Is the actual cooking of food prepared and cooked by the staff? ☐Yes ☐No
3. Are there fire extinguishers in the cooking area available? ☐Yes ☐No
4. Is the cooking equipment: ☐Residential ☐Commercial
5. Cooking equipment is equipped with:
   ☐Nothing ☐Hoods ☐Ducts ☐Exhaust Fans
   ☐Automatic Fire Suppression System ☐Automatic Fuel shut off control
6. How often is the cooking equipment cleaned?_____
7. Is the cleaning equipment: ☐Cleaned by Applicant ☐Cleaning Contractor
   If Applicant uses deep fat fryers, grills, or other cooking equipment other than a range, microwave or countertop electric heating device, please complete the following.
   a. Do all deep fat fryers have high limit switches? ☐Yes ☐No
   b. Does the extinguishing system have an accessible manual release control? ☐Yes ☐No
   c. List the brand name and age of the extinguishing system:_____
   d. Is the system U.L. listed? ☐Yes ☐No
   e. Is there an inspection / maintenance agreement? ☐Yes ☐No
      If yes, what is the frequency?_____
   f. How often is the hood and ductwork professional cleaned?_____
   g. What is the frequency and method of cleaning hoods and grease filters?_____
   h. Are grills equipped with grease traps? ☐Yes ☐No
   I. Are all flammables and combustibles (like paper goods, etc.) stored separately from ignition sources (like cooking areas, propane, etc.)? ☐Yes ☐No

SECTION IX - SECURITY

1. Does the Applicant have a written crisis management / emergency plan in effect? ☐Yes ☐No
   Does the plan apply to both on-premises and off-premises situations? ☐Yes ☐No
2. How often are evacuation drills performed?_____
3. Has the Applicant ever received any citations or warnings issued by any governmental entity? ☐Yes ☐No
   Please explain:

_____

SECTION X - AUTOMOBILE ☐N/A

1. Are all vehicles listed on the ACORD application titled to the Applicant? ☐Yes ☐No
   If no, please explain:_____
2. Where does the Applicant keep their owned vehicles?
   ☐Garage ☐Driveway ☐Parking Lot ☐Other:_____
3. Are keys locked and secured away from non-drivers when not in use? ☐Yes ☐No
4. Are vehicles with eight (8) or more seating capacity equipped with an audile backup warning device? ☐Yes ☐No
5. Does the Applicant provide transportation for:
   ☐Staff ☐Clients / Residents ☐Visitors / Public ☐Meals
   If yes for clients / residents, is more than one staff member required in the vehicle? ☐Yes ☐No
   If yes for meals, what precautions do you take to prevent food spoilage?

_____
6. Does the Applicant transport clients / consumers for other private or government agencies? ☐Yes ☐No
   If yes, please explain:

_____
   If yes, for a fee? ☐Yes ☐No
7. Does the Applicant provide transportation for field trips? ☐Yes ☐No
   If the Applicant does not provide transportation, how is it provided?

_____
   If vehicles are hired for field trips, are they hired with a driver? ☐Yes ☐No

8. Do employees / volunteers transport clients in their own vehicles? ☐Yes ☐No
   If yes, how often?_____
9. Are vehicles checked after passengers disembark to make sure no one is left behind? ☐Yes ☐No
10. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger? ☐Yes ☐No
11. Does the Applicant require seat belts to be worn by all occupants? ☐Yes ☐No
12. Does the Applicant have a vehicle maintenance program in place? ☐Yes ☐No
13. Does the Applicant's organization utilize GPS fleet telematics devices? ☐Yes ☐No
    If yes, please check off the fleet telematics being utilized:
    ☐Plug in ☐Hard wired ☐Mobile Phone ☐Other:_____
14. What percentage of the Applicant's fleet is provided with these fleet telematics devices? _____%

SECTION XI - DRIVERS ☐N/A

1. Does the Applicant obtain a written authorization to release driver information from all of the Applicants staff upon hiring? ☐Yes ☐No
   Does the Applicant obtain MVRs on all drivers? ☐Yes ☐No
   If yes, how often?_____
2. What are the Applicant's procedures for dealing with driver accidents or violations?

   _____
3. Are all drivers at least twenty-one (21) years of age? ☐Yes ☐No
4. How many drivers (employees and volunteers) aged twenty-one (21) to twenty-five (25) transport clients in agency vehicles?_____
5. Do any drivers have a Commercial Driver's License (CDL)? ☐Yes ☐No
6. Explain the Applicant's driver safety program:

   _____
7. Is training provided for new employees / volunteers prior to their transporting clients? ☐Yes ☐No
   If yes, please explain:

   _____
8. Does anyone besides employees or volunteers drive the Applicant's vehicles? ☐Yes ☐No
   If yes, please explain:

   _____
9. Does the Applicant allow personal use of the Applicant's agency vehicles? ☐Yes ☐No
   If yes, by whom and for what reasons?

   _____

SECTION XII – HIRED AND NON-OWNED VEHICLES ☐N/A

1. Does the Applicant hire vehicles? ☐Yes ☐No
   If yes, what type of vehicles does the Applicant hire?

   _____
   Does the Applicant obtain Certificates of Insurance from vehicle owners? ☐Yes ☐No
   What minimum limits does the Applicant require? $_____
2. Does the Applicant hire from a transportation company? ☐Yes ☐No
   If yes, with drivers? ☐Yes ☐No
3. Total number of hired vehicles:_____ Annual cost of hire: $_____
4. How many of the following drive personal vehicles for business use regularly? F/T: _____ P/T: _____ Vol: _____
   How many of the following drive personal vehicles for business use occasionally? F/T: _____ P/T: _____ Vol: _____
   Does the Applicant obtain proof of insurance for employees / volunteers who use their own autos? ☐Yes ☐No
   Does the Applicant update these records at least yearly? ☐Yes ☐No
   What minimum limits does Applicant require? $_____

SECTION XIII – DAY CARE ☐N/A

LICENSING:

1. Is the center licensed? ☐Yes ☐No
2. If licensing is NOT required, why is the center exempt?

   _____
3. Has a license to operate ever been denied, suspended or revoked? ☐Yes ☐No
   Attach a separate full explanation.
4. Has the Applicant ever been brought up for a compliance hearing? ☐Yes ☐No
   If yes, explain thoroughly on a separate document.

STAFF AND CHILDREN: (The ratios of staff-to-children must be at least the state required ratio)

1. Based on the **maximum number** of children enrolled on your **busiest** day OR busiest session, enter the numbers of staff and children in each of the following age groups. *(Do not duplicate pre and after school children if they stay all day)*

CHILD AGE GROUP	# OF CARE PROVIDERS	# OF CHILDREN
Less than 18 Months		
18 - 30 Months		
31 Months - 4Years		
Above 4 Years		
Preschool (**only**)		
After school (**only**)		

2. Is any staff less than 18 years old? ☐Yes ☐No
   Indicate specific duties for each on a separate document.
3. Does the Applicant use any volunteers? ☐Yes ☐No
   Indicate specific duties for each on a separate document.

HEALTH:

1. Does the Applicant provide **sick child, drop-in, latch-key, boarding or camp** services? ☐Yes ☐No
   If yes, please explain:

   _____
2. How many children require special care and treatment?_____
   Please explain:

   _____
3. Indicate if a file containing the following information is maintained on each child:
   a. Immunization records of the children being immunized successfully, and updated annually? ☐Yes ☐No
   b. Records for each child indicating unusual conditions the child has? ☐Yes ☐No
   c. Signed releases for emergency medical treatment/dispensing of medication obtained from parents? ☐Yes ☐No
   d. Written instructions from child's physician for dispensing of child's medication? ☐Yes ☐No
4. Is food properly covered, stored and served in accordance with applicable government requirements? ☐Yes ☐No
5. Does the Applicant have an accident/health policy? ☐Yes ☐No
   a. Is coverage mandatory for all children? ☐Yes ☐No
   b. Provide Carrier:_____
   c. Policy Term:_____ Limits: $_____

SECTION XIV - CAMPS ☐N/A

1. Is written permission and waiver of liability obtained from every child's parent or guardian? ☐Yes ☐No
2. Does the camp provide overnight services? ☐Yes ☐No
   If yes, what is the average length of stay?_____
3. Total number of days in operation annually:_____
4. Number of children at each camp:_____
5. Number of staff members at each camp:_____
6. What are the qualifications of staff working with children?

   _____
7. Are sleeping quarters co-ed? ☐Yes ☐No
8. Are restrooms / showers co-ed? ☐Yes ☐No
9. If well water, how often is it tested?_____

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10. Indicate and describe if any of the following exposures exists in the camp operations:
☐ Obstacle course ☐ Rock climbing ☐ Motor boats ☐ Horses ☐ Lakes ☐ Guns
☐ Diving boards ☐ Water skiing ☐ Jet skis ☐ Archery ☐ Pools

SECTION XV – ATHLETIC ACTIVITIES

1. Does the Applicant obtain a signed release which includes a hold harmless agreement from the parents/guardians of all participants and obtained annually? ☐Yes ☐No
2. Are there procedures in place to verify that parents / guardians carry their own health insurance? ☐Yes ☐No
3. Are medical exams required for all participants in extra-curricular sports? ☐Yes ☐No
4. Are all instructors Applicant's employees? ☐Yes ☐No
5. Is someone who is trained in first aid always present during practices and games? ☐Yes ☐No
6. Is Student Accident Insurance carried? ☐Yes ☐No
   If yes, what is the limit carried? $_____
7. Does the Applicant have a written concussion management protocol that is compliant with current state legislation? ☐Yes ☐No
   a. Does the Applicant distribute the written protocol to coaches, parents, and players, and require the parent / guardian's acknowledgement that they have received and reviewed? ☐Yes ☐No
   b. Does the protocol include training in recognizing the signs / symptoms of a concussion or other closed head injury? ☐Yes ☐No
   c. Does the Applicant utilize base line testing? ☐Yes ☐No
   Is the training required for all coaches and faculty involved in physical education or sports instruction? ☐Yes ☐No
   e. Does the protocol when a concussion is suspected require:
      i. removing the athlete or student from play? ☐Yes ☐No
      ii. evaluation by an appropriated healthcare professional? ☐Yes ☐No
      iii. informing the athlete or students' parents / guardians about the possibility of a concussion and giving them information about concussions? ☐Yes ☐No
      iv. keeping the athlete or student out of play until an appropriate healthcare professional certifies that the athlete or student is symptom free and gives the OK for them to return to play? ☐Yes ☐No
8. Does the Applicant have any saddle animals or equestrian teams? ☐Yes ☐No
9. Does the Applicant have any swimming pools on the premises? ☐Yes ☐No
   If yes, are all swimming pools and spas compliant with Virginia Graeme Baker Pool and Spa Safety Act? ☐Yes ☐No
   If no, provide time table and action plan:
   _____
10. Number of athletic trainers:_____
11. Is the Applicant compliant with the Zackery Lystedt law? **(only applicable in WA)** ☐Yes ☐No
12. Bleachers:
    # of Outside:_____ Seating capacity:_____ How often inspected:_____
    # of Inside: _____ Seating capacity:_____ How often inspected:_____
13. Are any of the following offered? (check all that apply)

☐ Archery	☐ Community Service	☐ Martial Arts	☐ Sky Diving
☐ Baseball	☐ Diving	☐ Motorbikes/Minibikes	☐ Snow Skiing
☐ Basketball	☐ Environmental Education	☐ Motorcycles/ATVs	☐ Soccer
☐ Bicycle Trips	☐ Equestrian	☐ Mountain Biking or BMX	☐ Softball
☐ Boxing	☐ Field Hockey	☐ Paintball	☐ Swimming
☐ Bungee Jumping	☐ Football (tackle)	☐ Polo	☐ Trampoline
☐ Ceramics / Pottery	☐ Football (touch or flag)	☐ Rocketry, Model Rockets	☐ Wall Climbing
☐ Cheerleading	☐ Go Karts	☐ Roller Skating / In-Line Skating	☐ Water Skiing
☐ Climbing (Mountain, Rock or Wall)	☐ Gymnastics	☐ Rugby	☐ Woodworking
☐ Crew/ Rowing	☐ Hiking / Backpacking	☐ Scuba Diving	☐ Wrestling
☐ Cross Country Track	☐ Ice Hockey	☐ Skateboarding	

☐ Other Unique Activities (Describe):

Depending on the activities indicated additional Underwriting information may be necessary. Some activities may be excluded from coverage after our evaluation.

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SECTION XVI – TRIPS / FIELD TRIPS / TRAVEL ☐ N/A

1. How many trips are sponsored each year?_____
2. Are all trips within the United States, U.S. Territories, or Canada? ☐ Yes ☐ No
   If no, where are trips taken?
   _____
3. Do any trips last more than one day? ☐ Yes ☐ No
   If yes, describe duration, destination(s) and purpose:
   _____
4. What is the ratio of adult staff to participants by age group?
   _____
5. Are signed permission and waiver agreements obtained from the custodial parent(s) for all trips a participant takes? ☐ Yes ☐ No
   If no, please explain Applicant's procedure for permissions and waivers:
   _____
6. Do all parents receive detailed information about the trip (place, transportation, supervision, times), objectives, necessary provisions and instructions prior to the trip? ☐ Yes ☐ No
7. Do all participants wear identification tags or identifiable clothing on all trips? ☐ Yes ☐ No
8. Does the Applicant hire an outside firm to arrange the trips? ☐ Yes ☐ No
9. Are participants allowed to drive their own cars on trips? ☐ Yes ☐ No
   If yes, are they allowed to transport other participants? ☐ Yes ☐ No
10. Is proof of insurance required for anyone who drives their own vehicle on a sponsored trip? ☐ Yes ☐ No
11. Is there a formal policy regarding emergencies and trained personnel on all trips? ☐ Yes ☐ No

SECTION XVII – SPECIAL NEEDS PARTICIPANTS ☐ N/A

1. What percent of the Applicant's participants have special needs? _____%
2. Do any of the Applicant's supervisory personnel have experience in an area relevant to the special needs participants you serve? ☐ Yes ☐ No
   If yes, describe type, training, and length of experience:
   _____
3. Are staff ratios adjusted for special needs participants? ☐ Yes ☐ No
   If yes, what is the ratio?_____ staff to _____ special needs participants
4. Is the supervisory staff informed about the limitations/abilities of the special needs participants regarding activities, diet, medical requirements, etc.? ☐ Yes ☐ No
5. Does the Applicant's crisis management plan include contingency plans for these participants? ☐ Yes ☐ No
6. Does the Applicant provide additional services, such as counseling hot lines, seminars, or other activities specific to special needs populations or their families? ☐ Yes ☐ No
   If yes, describe:_____

SECTION XVIII– FACILITY RENTAL ☐ N/A

1. Does the Applicant rent a facility to outside groups? ☐ Yes ☐ No
2. Is a written lease required for every rental? ☐ Yes ☐ No
3. Does the Applicant obtain a certificate of insurance with liability limits of at least $1,000,000? ☐ Yes ☐ No
   If yes, is the Applicant named as an additional insured on the lessees' liability insurance policy? ☐ Yes ☐ No
4. What are the Applicant's gross receipts from all rental operations? $_____
5. What activities are offered to rental groups?
   _____
   Does the Applicant provide supervision of any of these activities? ☐ Yes ☐ No
   If yes, which activities?_____
   Number of individuals/day:_____ Number of rental days/week:_____ Number of weeks/year:_____
6. Are all safety requirements spelled out in writing in the lease agreement? ☐ Yes ☐ No

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SECTION XIX – CLAIMS MADE

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

☐ N/A (Please proceed to signature section)

Policy Effective Date: _____

Line of Business: _____

1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the Applicant? ☐ Yes ☐ No
   If yes, please provide details:

2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying? ☐ Yes ☐ No
   If yes, please provide details:

SECTION XX - DIRECTORS & OFFICERS / EMPLOYMENT PRACTICE LIABILITY ☐ N/A

THIS SECTION IS AN APPLICATION FOR A CLAIMS MADE POLICY.
PLEASE READ YOUR POLICY CAREFULLY.

DIRECTORS & OFFICERS LIABILITY INFORMATION

1. Does the Applicant have a tax-exempt status under the U.S. Internal Revenue Code? ☐ Yes ☐ No
   If no, provide an explanation:

2.

FINANCIAL INFORMATION	CURRENT FISCAL YEAR	PREVIOUS FISCAL YEAR
Total Assets:	$	$
Net Assets / Fund Balance:	$	$
Annual Revenue:	$	$
Net Revenue:	$	$

3. Provide a list of all direct and indirect subsidiaries or any other entity or organization the Applicant controls:

Name / Type of Business	Percent the Applicant Owns/Controls	Date Created / Acquired	For Profit / Non-Profit
I.E.: ABC Foundation / Charitable Foundation	100%	01/01/2000	Non-Profit
	%		
	%		
	%		

☐ Additional entities listed by attachment

4. Has the Applicant or any person proposed for coverage herein been the subject of, or involved in, any of the following in the past five (5) years? If yes, please attach details. ☐ Yes ☐ No

   Any disciplinary action by any regulatory agency or association? ☐ Yes ☐ No
   Any administrative proceeding charging violation of a federal or state law or regulation? ☐ Yes ☐ No
   Any other criminal actions? ☐ Yes ☐ No

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5. In the past 24 or next 12 months has the Applicant been, or anticipate being involved in any merger, acquisitions or consolidation with another entity? ☐Yes ☐No
If yes, please attach details.

EMPLOYMENT PRACTICE LIABILITY INFORMATION:

1. Please provide the following employee count information:
U.S. based employees: _____
Total Full-Time: _____ Total Part-Time: _____
Volunteers: _____ Temporary: _____
Leased: _____ Total Non U.S. based employees: _____
TOTAL SUM OF ABOVE: _____

2. Has a reduction in employees or change in of status occurred in the past 12 months or is anticipated in the next 12 months?
Voluntary: _____ Involuntary: _____ Layoffs: _____

3. Does the Applicant have an employment handbook that includes an "At Will" statement? ☐Yes ☐No

4. Does the Applicant use an employment application for every potential employee? ☐Yes ☐No

5. Does the Applicant use outside employment counsel for employment advice? ☐Yes ☐No

6. Does the Applicant have a full time, dedicated human resource staff? ☐Yes ☐No

7. Total number of current employees with annual compensation greater than $100,000: _____

CURRENT COVERAGE:

COVERAGES	Insurance Company	Limit of Liability	Deductible	Policy Effective Dates	Premium
D & O		$	$		$
EPLI		$	$		$
Fiduciary		$	$		$
Workplace Violence		$	$		$
Internet Liability		$	$		$

WARRANTY INFORMATION:

1. With respect to this coverage, has any Underwriter refused, canceled or non-renewed coverage? **(Not Applicable in Missouri)** ☐Yes ☐No
If yes, please provide details:

_____

2. Has the Applicant given written notice under the provisions of any prior policies providing similar insurance or claims, or of specific facts or circumstances which might give rise to a claim being made against any person or entity applying for this insurance?
If yes, complete a Claim Supplemental for each incident. ☐Yes ☐No

3. No person applying for this coverage is aware of any facts or circumstances which he or she has reason to suppose might give rise to a future claim that would fall within the scope of any of the proposed coverages for which the Applicant has applied, except: ☐None or as noted below.

_____

With regard to questions 2. and 3., it is understood and agreed that if any such claim, act, error, omission, dispute or circumstance exists, then such claim and/or claims arising from such act, error, omission, dispute or circumstance is excluded from coverage that may be provided under this proposed insurance and, further, failure to disclose such claim, act, error, omission, dispute or circumstance may result in the proposed insurance being void, and/or subject to rescission.

WINTER WEATHER FREEZE-UP PROTECTION

This section must be completed by all risks that have a location in one of the following states: AR, CT, DC, DE, GA, IL, IN, KY, ME, MD, MA, MI, MO, NH, NY, NJ, NC, OH, PA, RI, SC, TN, TX, VT, VA, WV, WI

1. Fire Protection and Testing
   a. Is the building provided with an Automatic Fire Sprinkler System (AS)? ☐Yes ☐No ☐N/A
      i. If yes, approximately what percentage (%) of the building is sprinklered?_____%
      ii. If yes, what type of sprinkler system is installed? ☐Wet-Pipe ☐Dry-Pipe ☐Both
      iii. If yes, when possible, is the sprinkler piping primarily run within conditioned areas designed to ensure the temperature remains above the 45°F minimum temperature? ☐Yes ☐No ☐N/A
         1. If no, please describe freeze prevention measures (e.g. temperature monitoring, heat trace, full insulation on piping or roof):

      iv. If yes, is the testing & inspection by qualified sprinkler contractor completed within past 12 months & includes a formal winterization review? ☐Yes ☐No ☐N/A
      v. If yes, are the alarms tied to a 24 hour UL listed monitoring company? ☐Yes ☐No ☐N/A
2. Emergency Water Response (domestic and AS water lines)
   a. Are water shutoff valves (domestic and AS water lines) marked and readily accessible? ☐Yes ☐No ☐N/A
   b. Are water shutoff valves exercised (closed and reopened) at least annually? ☐Yes ☐No ☐N/A
   c. Is the staff qualified to respond and shut off the water main during normal business hours and off hours? ☐Yes ☐No ☐N/A
3. Automatic Water Shutoff Devices
   a. For domestic water lines, is there a water flow detection, notification and automatic shutoff? ☐Yes ☐No ☐N/A
4. Unused/Vacant Spaces
   a. Does Applicant have a formal process to turn off and drain domestic water lines for these spaces? ☐Yes ☐No ☐N/A
5. Unheated Areas (attics, crawl spaces, exterior wall joists)
   a. Are all domestic water lines located in areas heated to at least 45°F? ☐Yes ☐No ☐N/A
      i. If no, please describe freeze prevention measures (e.g. temperature monitoring, heat trace, full insulation):

6. General Comments:

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FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company**

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

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APPLICABLE IN PENNSYLVANIA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)

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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

Underwritten by:
Philadelphia Indemnity Insurance Company

CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

Name of Applicant:_____
Address of Applicant:_____
City:_____ State:_____ Zip:_____
Website: www:_____
Nature of Operations:_____

---

1. Annual sales or revenue: $_____

2. Does the Applicant collect, store or otherwise handle any Personally Identifiable Information (PII) belonging to customers, clients, or other third parties, other than employees? ☐ Yes ☐ No
   If yes, please indicate the types of Personally Identifiable Information held (check all that apply):
   - ☐ a. Social Security Numbers, Bank or Other Financial Account Details, Driver's License or other State Identification Numbers
   - ☐ b. Non-public Medical or Healthcare Data, including Protected Health Information (PHI)
   - ☐ c. Credit or Debit Card Information

3. a. During the last three (3) years, has anyone alleged that the Applicant was responsible for damage to their computer system(s) arising out of the operation of the Applicant's computer system(s)? ☐ Yes ☐ No
   b. During the last three (3) years, has anyone made a demand, claim, complaint, or filed a lawsuit against the Applicant alleging invasion or interference of rights of privacy or the inappropriate disclosure of Personally Identifiable Information (PII)? ☐ Yes ☐ No
   c. During the last three (3) years, has the Applicant been the subject of an investigation or action by any regulatory or administrative agency for privacy-related violations? ☐ Yes ☐ No
   d. Is the Applicant aware of any circumstance that could reasonably be anticipated to result in a claim being made against them for the coverage being applied for? ☐ Yes ☐ No

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NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)